TRANSPORTATION SERVICES MANUAL

Kentucky Medicaid Program

Cabinet for Health Services

Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

KENTUCKY MEDICAID PROGRAM

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SECTION I - INTRODUCTION

A. INTRODUCTION

This new edition of the Kentucky Medicaid Program Transportation Services Manual has been formulated with the intention of providing you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It shall assist you in understanding what procedures are reimbursable, and shall also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which shall allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (e.g., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Questions concerning the application or interpretation of agency policy with regard to transportation services shall be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Health Services, 275 East Main Street, Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims shall be directed to the fiscal agent.

II. KENTUCKY MEDICAID PROGRAM

A. General

The Kentucky Medicaid Program is administered by the Cabinet for Health Services, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint federal and state assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of this care. The basic objective of the Kentucky Medicaid Program shall be to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both federal and state statutes and regulations governing the administration of the State Plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to transportation providers for noncovered services.

The Kentucky Medicaid Program, Title XIX, shall not be confused with Medicare. Medicare is a federal program, identified as Title XVIII, basically serving persons sixty-five (65) years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. Program coverage and limitations of covered health care services specific to the Transportation program shall be specified in the body of this manual in Section IV.

B. Administrative Structure

The Department for Medicaid Services within the Cabinet for Health Services, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the program. The fiscal agent for the Department for Medicaid Services makes the actual payments to the providers of medical services who have submitted claims for services within the scope of covered benefits which have been provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medicaid benefits shall be a responsibility of the local Department for Social Insurance offices, located in each county of the state.

C. Advisory Council

The Kentucky Medicaid Program is guided in policy-making decisions by the Advisory Council for Medicaid. In accordance with the conditions set forth in KRS 205.540, the Council is composed of eighteen (18) members, including the Secretary of the Cabinet for Health Services, who serves as an exofficio member. The remaining seventeen (17) members are appointed by the Governor to four (4) year terms. Ten (10) members represent the various professional groups providing services to program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members are citizens of Kentucky who share a basic concern for health care in this state.

In accordance with the statutes, the Advisory Council meets at least every three (3) months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five (5) or six (6) member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible program recipients.

The 1967 amendments to the Social Security Law stipulate that Title XIX Programs have secondary liability for medical care costs of program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medicaid Program is payor of last resort. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided. If the provider should receive payment from the Medicaid Program before knowing of the third party's liability or receiving a third party payment, the provider shall refund that payment amount made by Medicaid, as the amount payable by the program shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, these polices are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid services in compliance with federal and state statutes regardless of recipient's sex, race, creed, religion, national origin, disability, or age.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

When the Department for Medicaid Services makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, and no payment for the same service shall be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

Providers of medical services or authorized representatives attest by their signatures (not facsimiles), on the claim form submitted, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment, or both. Stamped or computer generated signatures shall not be acceptable.

All claims and substantiating records shall be auditable by both the Government of the United States and the Commonwealth of Kentucky.

The provider's adherence to the application of policies in this manual shall be monitored through either postpayment review of claims by the Department or computer audits or edits of claims. When computer audits or edits fail to function properly the application of policies in this manual remains in effect. Therefore, claims become subject to postpayment review by the Department.

All claims and payments shall be subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services for recipients of this program shall be on a level of care that is equal to that extended to private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons **NOT** eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical specialty.

Provided services shall be periodically reviewed for recipient and provider abuse. Willful abuse by the provider may result in suspension from program participation. Abuse by the recipient may result in surveillance of the payable services he receives.

No claims shall be paid for services outside the scope of allowable benefits within a particular program specialty. Likewise, no claims shall be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program.

No claims shall be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of his or her liability for the charges for non-medically necessary and non-covered services.

When a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Efforts to Reduce Over-utilization by Beneficiaries

1. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary physician or family doctor. The primary physician shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services.

Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC) or AFDC related categories shall be covered by KenPAC. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) Card.

Recipients select a primary care physician who has agreed to participate in both the Medicaid and KenPAC programs. Recipients may change primary care physicians, if they wish. Likewise, a physician may choose to disenroll a particular recipient. Recipients not selecting a primary physician shall be assigned one by the Department.

Primary physicians shall arrange for physician coverage twenty-four (24) hours per day, seven (7) days per week. The recipient shall be able to contact the primary physician or another medical practitioner designated by the primary physician to receive necessary medical care at all hours of the day and night.

A twenty-four (24) hour access telephone number shall be provided by the primary physician. This telephone number shall be printed on the recipient's MAID card.

Referrals may be made by the primary physician to another physician for specialty care or for primary care during his absence or non- availability. No special authorization or referral form shall be required. Referrals shall occur in accordance with accepted practices in the medical community. For billing purposes, the primary physician shall provide the specialist or other physician with his provider authorization number, which shall be entered on the billing form to signify the service has been authorized. Preauthorization from the primary physician shall not be required for services provided for an emergency medical condition. If post treatment authorization cannot be obtained from the primary care physician, the provider may contact the Medicaid Program to obtain an authorization number before submitting a claim.

An "emergency medical condition" shall be defined as:

A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in

   (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

   (2) serious impairment to bodily functions; or

   (3) serious dysfunction of any bodily organ or part; or

B. With respect to a pregnant woman who is having contractions:

   (1) that there is inadequate time to effect a safe transfer to another hospital before delivery; or

   (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

A "transfer" shall be defined as the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who:

A. has been declared dead; or

B. leaves the facility without the permission of any such person.

2. Lock-in

The Department shall monitor and review utilization patterns of Medicaid beneficiaries to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the beneficiary. The Department shall investigate all complaints concerning beneficiaries who are believed to be over-utilizing the Medicaid Program.

In accordance with 907 KAR 1:677, Medicaid Recipient Lock-in, the Department shall determine the validity of the alleged over-utilization and take appropriate action, including the placement of a beneficiary into a restricted program, known as Lock-in. Under the Lock-in Program, the Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The beneficiary shall be required to utilize only the services of these providers, except in cases of emergency medical conditions and appropriate referrals by the case manager.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a beneficiary assigned to the lock-in program, unless the case manager has pre-approved a referral or for services provided for an emergency medical condition. Beneficiaries assigned to

the lock-in program shall have a pink MAID card and the name of the case manager shall appear on the face of the card. Claims resulting from a referral shall be considered for payment, provided that the name of the lock-in physician appear in the appropriate referral fields of the HCFA-1500 claim form.

Any questions concerning the Lock-in Program may be directed to the Surveillance Utilization Branch at (502) 564-2393.

F. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of times or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than

five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly, or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title,

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(C) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

G. Appeal Process for Refund Requests

If a refund request occurs subsequent to a postpayment review by the Surveillance and Utilization Review Branch (SURS), the provider may appeal the Medicaid agency request in writing by providing clarification and documentation that may alter the agency findings.

Written clarification shall be sent to:

DIRECTOR DIVISION OF PROGRAM SERVICES
DEPARTMENT FOR MEDICAID SERVICES
CABINET FOR HEALTH SERVICES
THIRD FLOOR EAST
275 EAST MAIN STREET
FRANKFORT KY 40621

If there has been no written response within thirty (30) days of the refund request, assent to the findings shall be assumed. If no arrangements for payment are made, the amount, requested shall be deducted from future payments.

H. Timely Submission of Claims

According to federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months of the adjudication date of Medicare or other insurance, or whichever is longer. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45 (d) (5) as follows: "The date of receipt is the date the agency received the claim as indicated by its date stamp on the claim." For Kentucky, the date received is included within the Transaction Control Number (TCN) which is assigned to each claim as it is received by the fiscal agent. The second through the sixth digits of the TCN identify the year and day of receipt, in that order (e.g., 09535400001000101 = December 20, 1995). The day is represented by a Julian date which counts the days of the year sequentially (January 1 = 001 through December 31 = 365 or 366). To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing RECEIPT by the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. ONLY twelve (12) months may elapse between EACH RECEIPT of the aged claim by the program.

SECTION III - CONDITIONS OF PARTICIPATION

A. Emergency Transportation Providers

1. An ambulance provider desiring to participate in the Kentucky Medicaid Program shall meet the requirements of the Kentucky Health Policy Board and be licensed in accordance with the Department for Health Services Emergency Medical Services Branch in at least one of the following categories of service:

    a. Advanced Life Support

    b. Basic Life Support

    c. Air ambulance

2. The provider shall submit to the Department for Medicaid Services, Provider Enrollment Section, the following:

    a. Provider Information Form (MAP-344),

    b. Two signed copies of the Provider Agreement (MAP-343),

    c. Two signed copies of the Certification on Lobbying (MAP-343-A),

    d. Two signed copies of the Disclosure of Ownership and Central Interest Statement (MAP-343B), and

    e. A copy of the provider's current license. In order to receive reimbursement as an ALS service, the provider shall provide proof of ALS licensing.

    f. Participation shall run concurrently with the dates of licensing. The provider shall submit a copy of his license annually.

2. Providers who bill electronically shall also submit:

   a. Two signed copies of the Electronic Billing Agency Agreement (MAP-246), and

   b. Two signed copies of the Provider Agreement Electronic Media Addendum (MAP-380 B).

B. Non-Emergency Transportation Providers

1. An ambulance provider desiring to provide routine non-emergency stretcher transportation shall meet the requirements of KRS 216B or the Kentucky Health Policy Board and be licensed by the Department for Health Services Emergency Medical Services Branch in at least one of the following categories of service:

   a. Advanced Life Support

   b. Basic Life Support

   c. Non-Emergency Health Transport (NEHT)

2. The provider shall submit to the Department for Medicaid Services, Provider Enrollment Section, the following:

   a. Provider Information Form (MAP-344),

   b. Two signed copies of the Provider Agreement (MAP-343),

   c. Provider Agreement Addendum/Non-Emergency Transportation,

   d. Two signed copies of the Certification on Lobbying (MAP-343-A),

e. Two signed copies of the Disclosure of Ownership and Central Interest Statement (MAP-343B), and

f. A copy of the provider's current license. Participation shall run concurrently with the dates of licensing. The provider shall submit a copy of his license annually.

g. Out of state providers shall submit a valid operating license annually, for each state in which they operate and have a physical site location.

3. Posting of Rates

All transportation providers, except private auto providers, shall be allowed to post their rates with the Department for Social Insurance offices in the counties which they serve. These rates shall apply for all Medicaid recipients and shall be effective for a twelve (12) month period and may be revised once per quarter. The rate charged to the Medicaid Program shall not exceed the rate charged to the general public.

C. General Information

1. Ambulance providers who desire to provide both emergency and non-emergency stretcher transportation services shall obtain two separate provider numbers.

NEHT providers who desire to provide wheelchair transportation shall be required to obtain a separate non-emergency provider number as a specialty carrier.

For participation in the Kentucky Medicaid Program, a Medicaid provider number shall be assigned to each provider.

Emergency ambulance provider numbers shall have a prefix of "55". Non-emergency transportation (ALS, BLS or NEHT) provider numbers shall have a prefix of "56". Failure to report the correct provider

number on the claim form submitted for services provided may result in incorrect or non-payment of claims. If a provider is terminated from Kentucky Medicaid participation, services provided to Kentucky Medicaid recipients after the effective date of termination shall not be payable.

2. Changes of address, telephone number, tax identification number, etc., shall be reported immediately in writing to Provider Enrollment and signed by authorized provider personnel.

3. Failure to submit a copy of the provider's current license shall result in denial of claims.

4. Providers shall comply with the Americans with Disabilities Act and any amendments thereto, and any rules and regulations thereafter.

5. Medical Records

Medical records in the office/clinic must substantiate the services billed to Medicaid by the provider. The medical records shall be accurate and appropriate, and entered personally or countersigned by the provider. Records maintained by emergency ambulance providers must maintain documentation as emergency services received in accordance with 907 KAR 1:060, Section 3. All records shall be signed and dated.

Medical records shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit exception or other dispute. The records and any other information regarding payments claimed shall be maintained in an organized central file and furnished to employees of the Cabinet for Health Services or Federal Government upon request, and made available for inspection and copying by Cabinet personnel.

D. Termination of Participation

Termination of a provider participating in the Medicaid Program shall be in accordance with the Department for Medicaid Services' administrative regulations which address the terms and conditions for provider termination and procedures for provider appeals.

SECTION IV - SERVICES COVERED

A. INTRODUCTION

The Kentucky Medicaid Program allows coverage for both emergency and non-emergency ambulance transportation to Medicaid-covered services. Covered emergency transportation services may be provided without prior authorization and may be billed directly to the Kentucky Medicaid fiscal agent.

All non-emergency transportation services shall be pre-authorized by the local Department for Social Insurance (DSI) office through the Locally Authorized Medical Transportation Program.

Covered services are outlined below.

B. Emergency Services

1. Definition

   a. "Advanced Life Support" (ALS) is defined as ambulance services meeting the standards for advanced life support services as set by the Department for Health Services, if provided by a Medicaid provider appropriately licensed by the Cabinet for Health Services for the provision of ALS services.

   b. "Basic Life Support" (BLS) is defined as ambulance services meeting the standards for basic life support services as set by the Department for Health Services, if provided by a Medicaid provider appropriately licensed by the Cabinet for Health Services for the provision of BLS services.

   c. "Air Ambulance" is defined as air ambulance services meeting the standards for provision of air ambulance services as set by the Department for Health Services, if provided by a Medicaid provider appropriately licensed by the Cabinet for Health Services for the provision of air ambulance services.

2. Services

   a. Emergency transportation to the emergency room of the nearest hospital shall be covered.

   b. If there is no hospital emergency room located within the medical service area, emergency transportation may be covered to another appropriate medical facility.
   NOTE: If the destination is not a hospital emergency room, a statement (MAP-720) that the Medicaid recipient received emergency treatment shall be obtained from the medical personnel who treated the recipient. A copy of the statement may be found in Appendix of this manual.

3. Limitations

   a. Only providers who have submitted proof of ALS licensing status shall be reimbursed for ALS services when ALS services are provided.

   b. ALS providers who do not submit this information shall be reimbursed as a BLS service.

   c. If the destination is not the emergency room of the nearest hospital and a completed MAP-720 is not attached to the claim, payment shall not be made.

   d. Payment shall only be made for eligible Medicaid recipients.

   e. Payment shall be made for loaded miles only.

   f. When a recipient is transported to the emergency room, the return trip (i.e., home, nursing facility, etc.) shall be considered a non-emergency service and shall be reimbursed at the non-emergency stretcher transportation reimbursement rate. The return trip shall not require pre-authorization, but the following criteria shall be met.

1) The initial trip shall be to the emergency room of a hospital.

2) The recipient shall be discharged from the hospital within 24 hours of the initial trip to the emergency room.

3) The return trip shall be billed on the same claim form as the initial trip to the emergency room.

C. Non-Emergency Services

1. Definition

a. "Non-emergency Health Transport Services" means a provider who is licensed as an ambulance provider (ALS, BLS or NEHT) and who provides medical transportation for non-ambulatory recipients who are required to travel by stretcher when no medical care or treatment of a recipient is required or indicated during transport.

c. Medical Service Area means the recipient's county of residence and contiguous counties.

d. Medical Necessity means that the recipient's medical condition requires stretcher transportation.

2. Services

Routine non-emergency stretcher transportation to Medicaid-covered services shall be covered when pre-authorized and approved by the local DSI office.

Procedures for pre-authorization are:

a. The recipient, or someone (other than the transportation provider) acting on behalf of the recipient, contacts the local DSI office to request authorization prior to the trip.

b. The recipient is traveling to a Medicaid-covered service.

c. It is medically necessary for the recipient to be transported by stretcher and this is documented with a statement of medical necessity.

The statement shall be from the recipient's physician (or, if the recipient is in a nursing facility, from the director of nursing, charge nurse, or medical director in lieu of physician) and shall verify that transportation by the stretcher is medically necessary due to the recipient's medical condition.

d. The recipient is traveling within the medical service area or has been given an appropriate referral by a local medical provider to travel outside the medical service area.

e. If the recipient requires oxygen during the non-emergency transport, the local DSI office shall be advised of this fact at the time authorization is requested.

3. Limitations

1. Payment shall not be made for transportation which was not pre-authorized or post-authorized in accordance with the above referenced criteria.

2. The provider shall not request authorization for the transportation.

3. Claims for payment which are submitted without the required statement of medical necessity shall not be paid.

4. Payment for transportation outside the local medical service area without an appropriate referral shall be at a reduced rate.

5. If the local DSI office was not advised of the need for oxygen at the time the authorization was requested, no payment for oxygen shall be allowed, except in extenuating circumstances.

6. Payment shall not be made for transportation to non-covered services.

7. Only the least expensive available transportation suitable for the recipient's condition shall be approved.

8. Payment shall be made only for eligible Medicaid recipients. Prior-authorization does not guarantee recipient eligibility. Prior-authorization means that the criteria for transportation have been met.

9. Payment shall not be made for transportation to a pharmacy solely for the purpose of obtaining pharmaceuticals.

10. Payment shall be made for loaded miles only.

11. Mileage for reimbursement purposes shall be computed by the most direct accessible route from point of pick-up to point of delivery.

D. Non-Covered Services

Reimbursement shall not be made for transportation provided in the following situations:

1. The recipient's condition, diagnosis, or circumstance does not require the use of an ambulance or stretcher.

2. The recipient is transported to a more distant facility solely to receive services of a hospital or physician of his choice.

3. Transport of a recipient pronounced dead at the scene by a licensed coroner shall not be covered.

4. The recipient has paid a subscription or membership fee.

5. Any use of ambulance transportation when there is other suitable means of transportation available shall not be covered.

Post-payment reviews shall be conducted to determine whether or not ambulance transportation has been used appropriately.

E. Inappropriate Use of Emergency Ambulance Service

Emergency ambulance services are covered under the Medicaid scope of benefits only when the condition of the patient requires the use of an ambulance, that is, when the patient, due to his medical condition, may not be safely transported by any other means. Ambulance service is not covered under the Medicaid scope of benefits if there is other means of transportation available. Post-payment reviews will be conducted to determine whether or not ambulance transportation has been used appropriately. A determination of inappropriate use of ambulance may be interpreted as fraud or abuse, and prosecuted in accordance with 907 KAR 1:671.

SECTION V - REIMBURSEMENT

A. Method of Reimbursement for Emergency Transportation

1. Reimbursement rates shall be based on four different levels of service:

   a. Air Ambulance Service to any destination when air ambulance transportation is medically necessary and appropriate. NOTE: Only providers who have submitted an Air Ambulance License shall be reimbursed at this rate.

      NOTE: All air ambulance claims shall be reviewed and either approved or denied by the DMS prior to processing.

   b. Advanced Life Support (ALS) Services when the destination is the emergency room of a hospital. NOTE: Only providers who have submitted proof of ALS status to the Provider Enrollment Section shall be reimbursed at these rates.

   c. Basic Life Support (BLS) Services when the destination is the emergency room of a hospital.

   d. ALS or BLS Service when the destination is to a facility other than the emergency room of a hospital for immediate emergency attention.

      NOTE: In order for reimbursement to be made for this level of service, a completed MAP-720 shall be attached to the claim form.

2. Providers of emergency ALS and BLS ambulance services shall be reimbursed at their usual and customary charges within program defined maximums.

Program reimbursement shall include the following components:

a. Base Rate,

b. Mileage for loaded miles,

c. A flat rate for oxygen, and

d. Disposable medical supplies which are reimbursed at cost

Note: The provider shall retain an invoice verifying the cost of disposable medical supplies and shall produce that invoice upon request by the department.

If more than one patient is transported during any of the above types of service, the reimbursement for the additional patient(s) shall be at a reduced base rate with no allowance for mileage. Oxygen and supplies shall be reimbursed in the usual manner.

3. Charges for the above services are submitted on the HCFA-1500 claim form.

B. Method of Reimbursement for Non-Emergency Transportation

1. Providers of non-emergency ambulance transportation service shall be reimbursed at their usual and customary charges within program defined maximums.

2. Program reimbursement for stretcher transportation shall include the following components:

a. Base Rate

b. Mileage for loaded miles

c. A flat rate for oxygen and oxygen supplies

SECTION V - REIMBURSEMENT

3. Program reimbursement for wheelchair transportation shall include the following components:

   a. Base rate

   b. Mileage for loaded miles

   c. A reduced base rate for an additional passenger, with no payment for mileage

4. A voucher system shall be used to reimburse providers for non-emergency ambulance service.

   a. When a trip is pre-authorized by the local DSI office, a voucher shall be issued to the recipient or person acting on behalf of the recipient who shall present it to the provider at the time of the trip.

   b. The provider shall complete the voucher, obtain the appropriate signatures and return it to the local DSI office where it was originally generated.

   c. The charges are transmitted electronically to the Medicaid fiscal agent by the local DSI office.

5. ALS providers, BLS providers and NEHT providers may provide non-emergency transportation services and shall be reimbursed in accordance with the above reimbursement methodology.

C. Method of Reimbursement for Air Ambulance Transportation

1. Providers of air ambulance services shall be reimbursed at their usual and customary charges within Program defined maximums.

2. Program reimbursement shall be an all-inclusive rate which includes the base rate, mileage, oxygen, supplies and personnel.

D. Reimbursement in Relation to Medicare

1. For recipients who have both Medicare and Medicaid, Medicare has first liability.

2. Medicaid shall make payment to the ambulance provider for the Medicare Part B outpatient deductible or co-insurance due for covered services which have been billed by the ambulance provider to the Medicare intermediary. In no case shall payment be made to the recipient.

3. A copy of the Medicare Remittance Advice shall be attached to the Medicaid claim form.

4. If a recipient has both Medicare and Medicaid, and if the transportation may be covered by Medicare, Medicare has first liability and the provider must bill Medicare first, and pre-authorization by the local DSI office shall not be required. If, however, Medicare subsequently denies the payment for the transportation, the provider shall obtain post-authorization. In order to have the transportation post-authorized, the provider shall give a copy of the Medicare denial to the local DSI office and a voucher shall then be issued. The voucher shall not require the signature of the recipient or the medical provider; only the signature of the transportation provider shall be required. These procedures shall not apply for trips to doctors' offices or other outpatient services for which Medicare never allows coverage; the procedures are to be used only for those trips which may reasonably assumed to be covered by Medicare.

NOTE: In order to obtain post-authorization on a Medicare denial, the medical necessity of the use of an ambulance must be documented in writing by a medical professional and attached to Medicare EOB presented to DSI.

E. Reimbursement in Relation to Other Third Party Coverage

1. The 1967 amendments to the Social Security Law stipulate that the Medicaid Program has secondary liability for eligible recipients. That is, if a recipient has an insurance company including automobile insurance that will pay for medical transportation, that insurance has first liability to pay for the service and the Medicaid Program has secondary liability. In the event that the Medicaid Program has already made payment for a transportation service and it is learned subsequently that another third-party source is liable for the bill, the transportation provider shall seek payment from that source and refund the appropriate amount to the Medicaid Program.

   Further information regarding third-party coverage may be found in Section VI of this manual.

F. Reimbursement in Relation to Subscription or Membership Fees

The policy of the Medicaid Program is that the provider may accept payment from the client or from the Medicaid Program, but not from both. If a recipient makes a payment for a covered service and the provider accepts that payment, no bill for the service shall be submitted to the Medicaid Program.

Likewise, when the Medicaid Program makes payment for a covered service and the provider accepts that payment, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Therefore, if it is the policy of the provider to charge a subscription or membership fee which entitles the customer to free or discounted ambulance transportation, and if a Medicaid recipient has paid that subscription or membership fee, no bills for that recipient shall be paid by the Medicaid Program.

G. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by Kentucky Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Kentucky Medicaid. Refund checks shall be made payable to "Kentucky State Treasurer" and submitted immediately with a Cash Refund Documentation Form to the fiscal agent.

Failure to refund a duplicate or inappropriate payment shall be reviewed to determine if a provider's action may have resulted in fraud or abuse. Providers shall be subject to provisions specified in 907 KAR 1:671 with regard to fraud or abuse activities.

The provider shall be entitled to appeal the agency refund request. This appeal shall be made in writing to the Department for Medicaid and should provide clarification and supporting documentation that alters the agency findings.

If there has been no written appeal by the provider within thirty (30) days of the refund request, assent to the findings shall be assumed. If no arrangements for payment are made, the amount requested shall be deducted from future payments by Kentucky Medicaid until full refund is recouped.

Written clarification or documentation related to the refund appeal shall be submitted to:

Department for Medicaid Services
Cabinet for Health Services
275 East Main Street
Frankfort, Kentucky 40621

SECTION V - REIMBURSEMENT

H. Payment by Recipient

Providers in the program shall report all payments or deposits made toward a recipient's account, regardless of the source of payment. If the provider receives payment from an eligible Medicaid Program recipient for a service provided that is a Medicaid covered service, the Medicaid Program regulations preclude payment being made by the program for that service unless documentation is received that the payment has been refunded to the recipient. This policy shall not apply to payments made by recipients for spend-down or non-covered services.

Recipients approved for Medicaid benefits on a spend down basis shall be obligated to pay fees to health care providers as assigned by their local Department for Social Insurance office where eligibility is established. These fees shall be paid to the providers by the recipients and shall satisfy the excess income for the period of eligibility. These payments by the recipients shall be reported by the provider on the claim form as payments from other sources.

Any item(s) or service(s) provided for Medicaid recipients non-covered by Kentucky Medicaid may be billed to the recipient or any other responsible party. Providers shall not collect payment from recipients for covered item(s) or service(s) for which Kentucky Medicaid has made payment. Any payment made by Kentucky Medicaid shall be accepted by the provider as payment in full for a service.

SECTION VI - THIRD PARTY COVERAGE

A. Third Party General Information

Pursuant to KRS 205.622, all Kentucky Medicaid participating providers shall submit claims for medical services to other responsible parties (e.g., Medicare or other third party insurer) prior to submitting claims to Kentucky Medicaid, when the provider has prior knowledge that another party may be liable for payment of recipient medical services.

To expedite the Medicaid claims processing payment function, the provider of healthcare services shall actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the providers obtain information related to Kentucky Medicaid from the recipient, they shall determine if additional resources exist. Providers shall have the obligation to investigate and report the existence of any third party payors or other liability by completing a Kentucky Medicaid Third Party Liability (TPL) Lead Form obtained from the fiscal agent. An example of this TPL Lead Form may be found in the Appendix of this manual.

Providers' cooperation in reporting other insurers (third parties) and completing TPL Lead Forms shall enable the Kentucky Medicaid Program to function more cost efficiently. Kentucky Medicaid shall be the payor of last resort.

SECTION VI - THIRD PARTY COVERAGE

Identification of Third Party Resources

1. General Healthcare Claims

In order to identify those recipients who may be covered by other health insurance resources, the provider or staff persons shall interview the recipient to substantiate whether or not any of the following conditions exist:

- Is the recipient married or employed? If the answer is yes, inquire about possible health insurance through the recipient's, or spouse's employer.
- Is the recipient a minor? If the answer is yes, inquire about insurance the **MOTHER, FATHER, OR GUARDIAN** may carry on the recipient.
- Is the recipient active or retired military personnel? If the answer is yes, request information about **CHAMPUS** coverage and the social security number of the policy holder.
- Is the recipient over the age of sixty-five (65) or disabled? If the answer is yes, seek **MEDICARE** information and number. It is requested that providers question the recipient in regard to any health insurance, e.g., a **MEDICARE SUPPLEMENT** policy; **CANCER, ACCIDENT, OR INDEMNITY** policy; **GROUP** health or **INDIVIDUAL** insurance, etc.

Individuals seeking Kentucky Medicaid eligibility are required to report the existence of any other insurance during eligibility interviews. Recipient **MAID** cards reflect information obtained during these interviews. Providers may examine the front side of the recipient's **MAID** card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.

The following list of insurance identification codes and descriptors appear on the backside of the **MAID** card to assist the provider with identification:

A - Part A, Medicare only
B - Part B, Medicare only
C - Both Parts A and B Medicare
D - Blue Cross/Blue Shield
E - Blue Cross/Blue Shield/Major Medical
F - Private Medical Insurance
G - Champus
H - Health Maintenance Organization
J - Unknown
K - Other
L - Absent Parent's Insurance
M - None
N - United Mine Workers
P - Black Lung
R - Medicare Part A, Medicare Premium Paid
S - Both Part A & B Medicare Premium Paid

2. Accident and Work-Related Claims

Providers who provide health care services for Medicaid recipients involved in accidents or work-related incidents shall assist Kentucky Medicaid, whenever possible, in the identification of potential third party resources which may be responsible for healthcare claims billed to Medicaid that are related to an accident or work-related incident. The provider shall pursue information related to the accident or work-related incident. If an employer, or another individual or insurance carrier, is the liable party, however, and that liability has not been clearly established, the provider may proceed to submit a claim

to Kentucky Medicaid for the services provided. The provider shall report to Kentucky Medicaid, however, any information obtained, e.g., names of representing attorneys, other involved parties, or the recipient's employer. This information shall be reported to the fiscal agent.

B. Third Party Payment, Rejection, or "No Response"

If the recipient has third party resources, the provider shall seek and obtain payment or rejection from the third party before Kentucky Medicaid may be billed. If a **PAYMENT** is received from this third party, the provider shall indicate on the claim form submitted to Kentucky Medicaid, in the appropriate field, the amount of the third party payment and the name and policy number(s) of the health insurance company insuring the recipient. If the third party **REJECTED** the claim, a copy of the rejection notice shall be attached to the claim submitted to Kentucky Medicaid for payment. This rejection notice may be in the form of a remittance statement or a letter from the insurance carrier.

- A **remittance statement** from the insurance carrier shall include the following information:

    1. Recipient name
    2. Date(s) of service
    3. Billed information that matches the billed information on the claim submitted to Medicaid.
    4. An indication of denial or that the billed amount was applied to the deductible.

NOTE: Rejections from insurance carriers stating "additional information necessary to process claim" shall not be acceptable.

- A **letter from the insurance carrier** signed by the insurance representative or transcribed on the insurance company letterhead shall include the following information:

    1. Recipient name
    2. Date(s) of service
    3. Termination or effective date of coverage
    4. Statement of benefits available (if applicable).

SECTION VI - THIRD PARTY COVERAGE

If neither remittance statement nor letter from the insurance carrier is obtained, the provider may contact the carrier by telephone and attach a letter to the claim submitted to Kentucky Medicaid stating that telephone contact was made with the insurance company related to the claim. This letter from the provider shall include the following information:

1. Recipient name
2. Date(s) of service
3. Name of insurance carrier
4. Name of insurance representative spoken to and the phone number (or notation indicating a voice automated response system was reached)
5. Termination or effective date of coverage
6. Statement of benefits available (if applicable).

NOTE: If no date(s) of service appears on the remittance statement or letter, as here described, the statement or letter shall only be accepted by Kentucky Medicaid for a maximum period of six (6) months from the earliest date of service reported on the claim form.

Providers who bill third party resources and receive no response within 120 days from the date of filing the claim may complete a Third Party Liability (TPL) Lead Form, report "No Response within 120 days"on the form, and attach it to the claim submitted to Kentucky Medicaid for payment.

Requests for TPL Lead Forms or information related to third party liability shall be addressed to the fiscal agent.

C. Third Party Insurance Termination

If a recipient's third party insurance coverage has been terminated, a provider may submit claims to Kentucky Medicaid for services provided and attach documentation, as described in Item B of this section, to any claim to prevent denial of payment for "other insurance coverage." If this documentation (remittance statement or letter from third party insurer) reports a specific date of insurance termination, it shall be forwarded to Recipient Eligibility where termination of "other insurance" may be entered into the recipient's eligibility profile. This action shall prevent future claim from denying for that specific insurance. If a provider submits a letter or remittance statement from the insurance company without a specific date of insurance termination or the documentation is a letter from the provider, the fiscal agent shall generate a questionnaire to the insurance company to obtain and verify the termination date. The recipient's file may be updated after a detailed response is received from the insurance company.

D. Third Party Payment in Relation to Kentucky Medicaid Payment

Claims meeting the requirements for Medicaid Program payment shall be paid in the following manner when a third party payment is identified on the claim.

1. Payment or Zero Payment

The amount paid by the third party shall be deducted from the Medicaid allowed amount. If third party payment(s) is less than the Kentucky Medicaid allowed amount for the same service and less than the usual and customary billed charge by the provider, Kentucky Medicaid shall allow additional payment amount(s) not to exceed the usual and customary billed charge or its maximum allowable fee for the service. If the third party payment exceeds the Medicaid allowed amount, the resulting Medicaid Program payment shall be zero. Recipients shall not be billed for any difference in healthcare costs. This Kentucky Medicaid zero payment shall be considered and accepted by the provider as "payment in full" for the service provided.

All providers shall have the choice of billing or not billing Kentucky Medicaid for claims which the provider has prior knowledge of zero payment by Medicaid; however, if the Medicaid Program is billed for the service, the provider shall accept Medicaid payment as payment in full.

2. Pursuit of Third Party Payment

If claims for a recipient are payable by a third party resource and not pursued by the provider, the claims shall be denied by Kentucky Medicaid. A Third Party Insurance Denial Explanation of Benefits (EOB) shall be issued to the provider. This denial may provide the name and address of the insurance company; the name of the policy holder; and the policy number, if it is known by Kentucky Medicaid. The provider shall pursue payment from this third party resource before billing Medicaid again.

3. Third Party Payment Received by Recipient

Kentucky Medicaid recipients shall be required by law (KRS 205.624) to assign to the Cabinet any medical benefits paid on their behalf by third party resources. When information exists to support that the recipient has received monies from a liable third party for medical services already paid by Kentucky Medicaid, the provider shall request and obtain any third party monies paid to the recipient. The provider may then file an adjustment to the claim previously paid by Kentucky Medicaid reporting the payment made by other insurance on the corrected claim form (refer to the billing packet).

Medicaid recipients shall have the right to request itemized account statements from their providers. Itemized statements shall be provided by the provider and include any payments made by Kentucky Medicaid or any payments pending Kentucky Medicaid reimbursement.

MEDICAID PROGRAM FISCAL AGENT INFORMATION

The Kentucky Department for Medicaid Services' fiscal agent, effective December 1, 1995, shall be the Unisys Corporation. Unisys can be reached as follows:

UNISYS CORPORATION ADDRESSESS

Accident & Work Related Claims
Post Office Box 2107
Frankfort, KY 40602

Adjustments & Claims Credits
Post Office Box 2108
Frankfort, KY 40602

Cash Refund
Post Office Box 2108
Frankfort, KY 40602

Claims Submission
Post Office Box 2101
Frankfort, KY 40602

Prior Authorization
P.O. Box 2103
Frankfort, KY 40602

Provider Relations (Inquiries)
Post Office Box 2100
Frankfort, KY 40602

Third Party Liability
Post Office Box 2107
Frankfort, KY 40602

Electronic Claims Submission
Post Office Box 2016
Frankfort, KY 40602

Unisys Corporation Telephone Numbers:

Kentucky		Out-of-State	
Drug Prior Authorization:	800-807-1273	Drug Prior Authorization:	502-226-1140
Electronic Claims:	800-205-4696	Electronic Claims:	502-226-1140
Provider Relations:	800-807-1232	Provider Relations:	502-226-1140

Automated Voice Response System:
Claims Status Inquiries: 800-807-1301
KenPAC Eligibility: 800-807-1301
Third Party Liability Eligibility: 800-807-1301

Provider Number (If Known) _____

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____ (Name of Provider) _____ (Address of Provider) hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a _____ (Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19___, with conditional termination on _____, 19___, and shall automatically terminate on _____, 19___, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

MAP-343 A
(11/91)

CERTIFICATION ON LOBBYING
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if any, and for this current contract period:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

(3/92)

PROVIDER AGREEMENT ADDENDUM/NON-EMERGENCY TRANSPORTATION

Each provider must select, from the following , one category (specialty) which accurately describes that provider's function. Failure to select a category will result in the return of this application.

_____ 01-Private Auto- (complete 572)

_____ 02-Taxi- (DOT, Division of Motor Carriers Certificate)

_____ 03-BUS/CITY- (DOT certificate; fixed route system)

_____ 04-BUS/CO-OP- (DOT certificate; Section 18 or 16(B) (2) vehicles; Federal/State Funding, excluding Medicaid reimbursement)

_____ 05-Bus/Inter-Intra State (Commercial)

_____ 06-Airplane-(FAA Certification)

_____ 07-Ambulatory Specialty Carrier (same as 08)

_____ 08-Non-Ambulatory Specialty Carrier-(Proof of compliance with ADA, or DOT Authorization for vehicles with special equipment).

CONTACT PROVIDER ENROLLMENT AT (502) 564-3476 FOR FURTHER INFORMATION REGARDING SPECIALTIES 09-15.

_____ 09-Air Ambulance

_____ 10-Helicopter

_____ 11-Ambulance

_____ 12-Train

_____ 13-Chartered Air Craft

_____ 14-Government Air Craft

_____ 15-Rental Vehicle

If more than one category (specialty) is selected, additional agreements will be required.

Please list the counties served by your transportation business.

_____

_____

MAP-343B (8/93)

KENTUCKY MEDICAID PROGRAM

Disclosure of Ownership and Control Interest Statement
(Completion of this form is a mandatory participation requirement pursuant to 42 CFR 455.104.)

1. _____ (Provider Name) _____ (KY Medicaid Provider #)

2. _____ (Physical Location Address: Street, Route)

3. _____ (City) _____ (State) _____ (Zip Code)

4. List the name and address of each person or organization having direct or indirect ownership or control interest in the disclosing entity as defined by 42 CFR 455.101.

_____

_____

_____

_____

_____

5. List the name and address of each person with an ownership or control interest, as defined by 42 CFR 455.101, in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more.

_____

_____

_____

6. Are any of the individuals in items 4 and/or 5 related to one another as spouse, parent, child, or sibling (including step and adoptive relationships)?
__ YES __ NO

7. If answer to #6 is yes, complete the following information.

Names	Relationship

8. List the name of any other disclosing entity in which person(s) listed in #5 have an ownership or control interest as defined by 42 CFR 455.101.

9. List the name of any individual or organization identified in item #4 who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII (Medicare), Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act.

10. List the name of any agent or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX of the Social Security Act.

WHOEVER KNOWINGLY OR WILLFULLY MAKES, OR CAUSES TO BE MADE, A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT SHALL BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAWS. FAILURE TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED SHALL RESULT IN A DENIAL OF A REQUEST TO PARTICIPATE OR IN TERMINATION OF THE CURRENT AGREEMENT WITH THE STATE AGENCY, AS REQUIRED BY 42 CFR 455.104.

(Signature) (Date)

(Typed Name of Authorized Representative) (Title)

MAP-344 (Rev. 8/93)

KENTUCKY MEDICAID PROGRAM

Provider Information

1. _____ (Name) _____ (County)

2. _____ (Physical Location Address: Street, Route)

3. _____ (City) _____ (State) _____ (Zip Code)

4. _____ (Office Phone # of Provider) _____ (Billing Office Phone # and Contact Person)

5. _____ (Pay to Address, if Different From Physical Location)

6. _____ (City) _____ (State) _____ (Zip Code)

7. _____ (Federal Employee I.D. #) 8. _____ (Social Security #)

9. _____ (License #) 10. _____ (Medicare #) 11. _____ (UPIN #)

12. _____ (Licensing Board) 13. _____ (Original License Date)

14. _____ (CLIA #) 15. _____ (Type of Certificate) (Attached)

16. Physician/Professional Specialty Certification Board:

_____ Date _____

1st _____ Date _____

2nd _____

Attach Copy of Board Certification.

17. Federal DEA # and Date Assigned: _____

18. Practice Organization/Structure:

_____ (1) Corporation
_____ (2) Partnership
_____ (3) Individual
_____ (4) Sole Proprietor
_____ (5) Public Service Corporation
_____ (6) Estate/Trust
_____ (7) Government/Non-Profit

19. If Corporation, list name and address of officers:

_____

_____

_____

_____

_____ _____
(Corporate Office Address) (Telephone #)

_____ _____ _____
(City) (State) (Zip Code)

20. If partnership, list name and address of partners:

_____

_____

_____

_____

21. If sole proprietor, give name, address, and phone number of owner:

_____

_____

_____

_____

_____

22. Control of Medical Facility:

_____ Federal _____ State _____ County- _____ City
_____ Charitable or Religious _____ Proprietary (Privately-Owned)
_____ Other

23. If facility is government owned, list names and address of board members:

President/Chairman

_____

Member: _____

Member: _____

24. Distribution of beds in facility:

Acute Care _____ Psychiatric _____ Swing _____

Nursing _____ MR/DD _____

25. Fiscal Year End: _____

26. Administrator: _____ Phone #_____

27. Assistant Administrator: _____ Phone #_____

28. Controller: _____ Phone #_____

29. Accountant or CPA: _____ Phone #_____

30. Management Firm: _____

31. Lessor: _____

32. Has this application been completed as the result of a change of ownership or a change of tax ID number for a previously enrolled Kentucky Medicaid provider?

____Yes ____No

If yes give previous Kentucky Medicaid provider #:_____

33. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____ Date: _____

Name: _____

Title: _____

Return all enrollment forms, changes, and inquiries to:

Medicaid-Provider Enrollment
CHR Building, Third Floor East
275 East Main Street
Frankfort, KY 40621

INTER-OFFICE USE ONLY

License Number Verified through _____ (Enter Code)

Comments: _____

_____

Date: _____ Staff: _____

MAP-380 (Rev. 04/90)

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____, Name and Address of Provider hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as a

_____, _____
(Type of Provider and/or Level of Care) (Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

   A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.

   B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.

   C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

   "This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal and State Law."

D. Agrees to use EMC submittal procedures and record layouts as defin. by the Cabinet.

E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.

F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.

2. The Cabinet:

A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.

B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

C. Reserves the right of billing the provider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER

BY: _____
Signature of Provider

Contact Name: _____

Title: _____

Date: _____

Telephone No.: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

BY: _____
Signature of Authorized Official
or Designee

Name: _____

Title: _____

Date: _____

MAP-246 (Rev. 04/91)

Agreement Between the
Kentucky Medicaid Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The _____ has
(Name of Billing Agency)

entered into a contract with _____,
(Name of Provider)

_____, to submit claims via electronic media for services provided to
(Provider Number)

KMP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;

2. To maintain or have access to a record of all claims submitted for payment for a period of at least five (5) years, and to provide this information to the KMP or designated agents of the KMP upon request;

3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.

4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;

2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

_____
Signature, Authorized Agent of Billing Agency

Date:_____

Contact Name:_____

Telephone No.:_____

Software Vendor
and/or Billing Agency:_____

Media:_____

_____
Signature, Representative of the
Department for Medicaid Services

Date:_____

MAP-13

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

PROVIDER
VOUCHER
COUNTY
DATE

LOCALLY AUTHORIZED MEDICAL TRANSPORTATION

THIS VOUCHER AUTHORIZED PAYMENT TO
(NAME OF PROVIDER)
FOR MEDICAL TRANSPORTATION SERVICES PROVIDED ON (DATE) FOR THE
FOLLOWING RECIPIENT
(RECIPIENT NAME) (MAID NO.)

DESTINATION:
TO:
FACILITY
ADDRESS
CITY
STATE

FROM:
FACILITY
ADDRESS
CITY
STATE

PROVIDER TYPE:
ONE WAY ( ) ROUND TRIP ( )
NO. OF MILES: _____
TOTAL CHARGE: _____
ADDITIONAL PASSENGER ( )
PAYMENT MAXIMUM
$6.00 ( ) $12.00 ( )

_____
(WORKER SIGNATURE)

THIS VOUCHER IS ONLY GOOD FOR DATE OF SERVICE. INVALID IF ALTERED OR IF RECIPIENT IS INELIGIBLE FOR MEDICAL ASSISTANCE. PLEASE REVIEW THE RECIPIENT'S MAID CARD FOR ELIGIBILITY DATES.

FOR SPECIALTY CARRIER USE ONLY

NAME OF SPECIALTY CARRIER _____ TOTAL MILES _____
NUMBER OF PASSENGERS IN VAN _____ NON-AMBULATORY (WHEELCHAIR) _____
AMBULATORY (DISORIENTED PERSONS) _____ NUMBER OF MILES OVER BASE _____

I HAVE PROVIDED THE SERVICES DESCRIBED ON THIS VOUCHER IN ACCORDANCE WITH POLICY AND PROCEDURE SET FORTH BY THE KENTUCKY MEDICAL ASSISTANCE PROGRAM AND WILL ACCEPT THE ESTABLISHED KMAP ALLOWABLE MAXIMUM PAYMENT AS PAYMENT IN FULL. I UNDERSTAND THAT PAYMENT SATISFACTION OF THIS CLAIM WILL BE FROM STATE AND FEDERAL FUNDS, AND THAT ANY FALSE STATEMENT, CLAIMS, DOCUMENTS, OR CONCEALMENTS OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE STATE AND FEDERAL LAWS.

_____
(PROVIDER SIGNATURE)

I VERIFY THAT
MEDICAL SERVICE ON

WAS AT MY OFFICE/FACILITY TO RECIEVE A

_____
(MEDICAL PROVIDER SIGNATURE)

I CERTIFY THAT I HAVE RECEIVED THE ABOVE DESCRIBED SERVICES:

_____
(RECIPIENT SIGNATURE)

AUTHORIZATION FOR EMERGENCY AMBULANCE SERVICES TO FACILITY OTHER THAN A HOSPITAL EMERGENCY ROOM

I, _____, licensed medical professional at
(Name)

_____ _____
(Medical Facility) (Address of Facility)

do hereby certify that _____
(Recipient Name and MAID Number)

required the use of emergency transportation and required and received the following emergency medical treatment on _____:
(Date)

Treatment: _____

_____

Diagnosis: _____

The reason the patient was not transported to a hospital emergency room is:

_____

_____
Printed Name of Licensed Medical Professional

_____
Title

_____
Signature of Same Date

NOTE: This form must be completed in its entirety. The information contained herein is subject to audit by representatives of the Department for Medicaid Services, the Office of the Inspector General and the Health Care Finance Administration (HCFA).

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Appendix V

HEALTH INSURANCE CLAIM FORM

CARRIER

PICA | MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

(Medicare #) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | (ID)

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single Married Other / Employed Full-Time Student Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500
APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 CHAMPUS

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